

VDH-OMHHE-VIRGINIA'S NURSE PRACTITIONER/NURSE MIDWIFE SCHOLARSHIP PROGRAM 2015 APPLICATION

APPLICATION CHECKLIST REQUIREMENTS

This checklist must be reviewed thoroughly and submitted as part of a completed application. Incomplete applications will not be considered for award and failure to comply with any of these application requirements will result in the applicant being ineligible for award.

The Nurse Practitioner/ Nurse Midwife Scholarship Program provides scholarship awards to students who agree to practice full-time as a Nurse Practitioner or Nurse Midwife in a medically underserved area of Virginia. All awards are made by a Nursing Scholarship Committee, appointed by the State Board of Health. The Office of Minority Health and Health Equity (OMHHE) of the State Health Department serves as the staff element to the Nursing Scholarship Committee and has no role in the determination of scholarship awarded to recipients. The guidelines for determining scholarship awards to recipients are established by the Nursing Scholarship Committee. Preference for the scholarship award shall be given to residents of the Commonwealth of Virginia who are minority students, students enrolled in Family Practice, Obstetrics, Gynecology, Pediatrics, Adult Health, and Geriatric Nurse Practitioner Programs. Participants residing in Medically Underserved Areas (MUA's) as determined by the Board of Health will also be given preference. In order to be considered for the Nurse Practitioner/Nurse Midwife Scholarship program, the following are required:

- ☐ Applicant must be a United States Citizen , National, hold an immigration visa or classified as a political refugee as verified by a social security number included in the application. **Persons with a temporary or student visa are not eligible.**
- ☐ Applicant must be a resident of the State of Virginia for at least one year. Verification provided must prove that the applicant has lived in Virginia for at least one year (ex. Renewal date on driver's license, previous year on voter registration card, motor vehicle registration/employment records/deed of property/ sources of financial support, etc if they reflect multiple years). Please provide one of the following appropriate forms of verification: 1.) State Income Tax record or statement 2.) Driver's license with renewal information 3.) Voter registration card 4.) Motor vehicle registration 5.) Employment record 6.) Ownership of real property 7.) Financial support records.
- ☐ Applicant must attach a one page Narrative Summary. **"Section 7-Narrative Summary" must be printed at the top of the page. The applicant should sign and date the bottom of the page. (The Narrative Summary will not be accepted if not submitted as stated above.) In one page or less,** the summary must briefly explain the significance of the Virginia Nurse Practitioner/Nurse Midwife Scholarship in pursuing the applicant's educational goals, any school/community activities, and any skill-set that is pertinent to the nursing profession. **If the Narrative Summary exceeds the one page limit, it will not be accepted.** Please include:
 1. Scholastic attainment
 2. Character attributes and adaptability to the nurse practitioner/nurse midwife profession
 3. Plans for practicing in Virginia following graduation
 4. Any specializations in the following areas: family practice, obstetrics and gynecology, pediatrics, adult health, and geriatric nurse practitioner programs.
 5. School and/or community activities
 6. Any skill sets pertinent to the profession
- ☐ Applicant must be accepted to or enrolled in a school of nursing in the State of Virginia which is approved by the State Board of Nursing. The applicant must have the Dean/Director/Chair of the Applicant's School of Nursing complete **Section 8** of the application, provide an **original signature** and have it returned to him/her to be submitted with the application. **Section 8 will not be accepted if it is not submitted with the application.**
- ☐ Applicant **must attach an official transcript** of grades from all schools attended. **The transcript will not be accepted if it is not submitted with the application.** The applicant must demonstrate a cumulative Grade Point Average (GPA) of at least 2.5 if currently enrolled in and attending a nursing program.
- ☐ **Applications must be typed and have all appropriate documents attached.** Applicants are advised to keep a copy for their records. Application open period is **May 1 to June 30** for the fall academic year. Applications are not accepted prior to May 1st, and must be **postmarked by June 30th.** Please mail completed applications to:

*Virginia Department of Health
Office of Minority Health and Health Equity
ATTN: Workforce Incentive Programs
109 Governor St., Suite 1016-East Richmond, Virginia 23219*

If you have any questions, please contact The Office of Minority Health and Health Equity at 804-864-7435.

Note: Minority students are defined as students of one or more of the following federally recognized minority populations: African American/Black, Hispanic/Latino, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native. Medically Underserved Areas (MUA's) can be located at <http://www.vdh.virginia.gov/OMHHE/primarycare/shortagedesignations/index.htm> or by contacting Ken Studer at 804-864-7435.

SECTION 1 – PERSONAL DATA

Please Select One: ☐ Nurse Practitioner

☐ Nurse Midwife

Date of Application: _____

Legal Name:

Last First MI Maiden

Preferred Name:

Address:

Street Address

City State Zip

Day Phone Number:

_____ Evening Phone Number: _____

Email Address:

Social Security Number:

_____ Sex: Please Select One

Date of Birth and Age: _____ Place of Birth: _____

Race/Ethnicity: Please Select One Other: _____

How long have you been a resident of Virginia? _____

Do you live in a Medically Underserved Area? Please Select One

What is your Congressional District: _____
(Please check with your voter registration office or visit
<http://nationalatlas.gov/printable/congress.html>)

Do you have an active military service obligation? Please Select One

Are you a high school graduate? Please Select One Do you possess a GED? Please Select One

Have you ever received a Nurse Practitioner/Nurse Midwife Scholarship? Please Select One

If yes, in what year(s)? _____

If you had a different name when you applied previously, please provide it here: _____

VIRGINIA DEPARTMENT OF HEALTH-OMHHEVirginia's Nurse Practitioner/Nurse Midwife Scholarship 2015 Application - *Revised 5-2015*

What school of nursing were you attending during that time? _____

Do you speak another language? Please Select One If yes, please
list: _____**ALTERNATE CONTACT PERSON (OTHER THAN APPLICANT)**Name: _____
Last First MIAddress: _____
Street Address
City State Zip

Phone Number: _____ Relationship to Applicant: _____

SECTION 2 – NURSING EDUCATION

Current Graduate School
of Nursing: _____Student Identification or
Social Security Number: _____Address: _____
Street Address
City State Zip

Phone Number : _____

If part-time, how many credit hours are you taking? _____

☐ Full-time Student: ☐ Part-time Student:Have you transferred to this school from another nursing program? Please Select One

Name of previous school: _____

Date of enrollment in present Nursing Program: _____
Month Day YearExpected date of graduation: _____
Month Day Year**Nursing Program Level: Please check the program type and current level. Specify level in September.**

<u>Program</u>	<u>Specialty</u>	<u>Current Level</u>	<u>Level in September</u>
<u>Please Select One</u>	<u>Please Select One</u>	<u>Please Select One</u>	<u>Please Select One</u>

SECTION 3 – PRIOR EDUCATION

Please check all that you have successfully obtained:

☐ CNA ☐ LPN ☐ ASN ☐ BSN ☐ Other:

Current License: _____ Current License Number: _____

Please provide the following information:

	School and Program	Diploma/Degree/ Certificate	City and State	Dates of Attendance	Reason for Leaving
1.				to	
2.				to	
3.				to	
4.				to	
5.				to	

SECTION 4 – WORK EXPERIENCE

☐ *Check here if you have never been employed, and skip to Section 5*

	Position	Name of Employer	City and State	Dates of Employment	Reason for Leaving
1.				to	
2.				to	
3.				to	

SECTION 5 – OTHER HEALTH-RELATED AND/OR CIVIC EXPERIENCES

☐ *Check here if you have never been involved in any health related and/or Civic activities, and skip to Section 6*

	Position	Organization	City and State	Dates of Activities
1.				to
2.				to
3.				to

SECTION 6 – OTHER FINANCIAL ASSISTANCE (including other scholarships and grants)

Are you receiving any other type of financial assistance for the upcoming school year? Please Select One

Please indicate:

SECTION 7 – NARRATIVE SUMMARY (Required on an attached sheet)

Briefly explain, *in one page or less*, the significance of the Virginia Nurse Practitioner/Nurse Midwife Scholarship Program in pursuing your educational goals. Be sure to include your scholastic attainment, character, and adaptability to the nurse practitioner/nurse midwife profession if applicable. It is important to mention plans for practicing in Virginia following graduation and any specializations in the following areas: family practice, obstetrics and gynecology, pediatrics, adult health, and geriatric nurse practitioner programs. Also, include school and/or community activities as well as any skill-set that is pertinent to your profession. Applicant **must** label the top of the attached sheet "**Section 7-Narrative Summary**" print name, provide an original signature, and the current date. **If the Narrative Summary exceeds the one page limit, it will not be accepted.**

SECTION 8 – SCHOOL OF NURSING RECOMMENDATION

To be completed by the Dean/Director of the School of Nursing

1. Name of applicant: _____
2. Student Identification or Social Security Number: _____
3. This applicant is: Please Select One
4. State Date: Month _____ Year _____
5. During this award period, the applicant will be a: Please Select One
6. *If the student is currently enrolled in your Nursing Program, please select one of the following:*
Please Select One
7. *If student is currently enrolled in your Nursing Program, please provide a cumulative GPA of current nursing courses. Applicants must have at least a 2.5 cumulative GPA in Required Nursing Courses, electives should not be considered in the Cumulative GPA: List GPA* _____

Source of computing GPA: Please Select One If other, please specify:

Please provide a brief recommendation (in 1,600 characters or less) regarding the student based on the student's scholastic attainment, character, need, adaptability, and/or other attributes. Please mention any progress in the following areas of specializations: family practice, obstetrics and gynecology, pediatrics, adult health, and geriatric nurse practitioner programs.

Please provide an original signature from authorized personnel.

I recommend _____ for a Nurse Practitioner/Nurse Midwife Scholarship Award.
Full Name of Applicant

Name of Authorized Personnel Completing This Section

Title

Signature

Date

Full Name of School of Nursing

Phone Number

E-mail Address

SECTION 9 – FINANCIAL NEED RECOMMENDATION

To be completed and signed by the Financial Aid Officer, Program Director or Authorized Personnel.

This section must include a monetary recommendation. The Mary Marshall Nursing Scholarship is a need-based aid program; therefore, the amount recommended must be documented by one of the accepted uniform methodology needs analysis systems. Please use the most recent needs analysis on file for this student to recommend the amount of scholarship required to meet need, after taking into consideration other financial aid already received by the applicant.

1. Applicant Name: _____
2. Student Identification or Social Security Number _____

3. Student Costs and Resources:

Student Aid Budget for Applicant _____

Expected Family Contribution (EFC) _____

Financial Aid Received (excluding loans) _____

Remaining Need _____

Cost of Program for One Year (Including tuition, fees, books, uniform, etc.) _____

4. Scholarship Recommendation:

Award range for undergraduates must be at least \$150.00 and must not exceed \$2,000 annually. Mary Marshall Nursing Scholarship Committee will not make an award that exceeds the financial aid officer's recommendation listed above.

After reviewing the applicant's financial situation, I recommend a Mary Marshall Nursing Scholarship award of (*check one*):

☐ \$150 to \$600 Annually ☐ \$601 to \$1,200 Annually ☐ \$1,201 to \$2000 Annually

If your recommendation is less than both the "remaining need" above and the maximum allowable reflected in the award range above, please explain:

5. Needs Analysis Method Used:

Please indicate which of the following methods was used to determine the applicant's financial need and the academic year for which the form was filed. (Financial Aid Officers are encouraged to use the need analysis for the year in which the student is applying for assistance.)

<input type="checkbox"/> CSS	<input type="checkbox"/> ACT	<input type="checkbox"/> PELL	<input type="checkbox"/> FAFSA	Academic Year: 2015 to 2016
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6. Please specify any extenuating circumstances which may have influenced your recommendation.

Please provide an original signature from authorized personnel.

Name of Financial Aid Officer/Authorized Personnel (Please Print)

Phone Number

Signature of Financial Aid Officer/Authorized Personnel

Date

E-Mail Address:

SECTION 10 – COMMITMENT OF SERVICE

Do you plan to seek employment in an area officially designated as a Medically Underserved Area (MUA) ?

Please Select One

Do you plan to seek employment and serve in an employment setting that provides services to persons who are unable to pay for the service and participates in all government sponsored insurance programs designated to assure access to medical care services for covered persons?

Please Select One

SECTION 11 – CERTIFICATION STATEMENT

I, the undersigned, hereby certify that, all of the information on this scholarship application is true and complete to the best of my knowledge. I realize that information from this application will be used to determine scholarship eligibility. If asked by the Nursing Scholarship Advisory Committee, I agree to provide documentation verifying any information on this application. I have read and accept the conditions of the Virginia Nurse Practitioner/Nurse Midwife Scholarship Program.

Signature of Applicant

Date

Full Name (Please Print)

Any persons dissatisfied with the award or denial of an application to become a scholarship participant must notify staff of the Nursing Scholarship Advisory Committee within 14 days of receiving notification of the award or denial of an application.

For marketing purposes, how did you learn about this scholarship opportunity? _____

Thank you for your interest in this program!

Staff Record Only: ☐ *Application complete upon receipt* ☐ *Additional information requested*